	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) [redacted] General Practitioner, 111 Basildon Road, Abbey Wood, SE2 0ER** **(2) [redacted] Medical Director for South London NHS England 1 Lower Marsh, Waterloo, London, SE1 7NT**
1	**CORONER** I am Dr Andrew Harris, Senior Coroner, London Inner South
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** On 15th March 2012, I opened an inquest into the death of: **Lisa Webb, aged 44, died 10th March 2012, Case Ref: 00661-12.** It was concluded on 7th April 2014. The court found that death was due to natural causes. 1a Adult Respiratory Distress Syndrome 1b Lower Respiratory Tract Infection II Sleep apnoea and chronic asthma
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were recorded as: *Ms Webb had a salivary stone removed under local anaesthetic on 8th March 2012 and attended GP surgery the next day, where she was found to be anxious and given a small dose of Diazepam. She died suddenly unexpectedly without prior overt respiratory symptoms, in her bed at home. She was beyond resuscitation and was certified dead at 00.57 on 10/03/12. Surgery and medical treatment did not contribute to her death, which was from natural causes.*
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Expert evidence was heard that: (1) The management of asthma by the general practitioner on 9th March 2012, when she presented post-operatively with fast breathing and anxiety, was sub-optimal and creates potential risks for other patients. a) Enquiries about her asthma and use of inhalers were not made, before a diagnosis was made of anxiety related hyperventilation (which was not in previous medical history) b) Fast breathing was observed and recorded as hyperventilating and mild wheeze, but the respiratory rate not recorded, nor was her pulse rate. c) Her peak flow rate was not recorded. There was only one record of its being measured in the years of general practice care and that was in 2008, when she was given a steroid inhaler.

	d) Pulse oximetry was not used (2) The prescription of Diazepam, although it did no harm in this instance, was poor treatment for anxiety, it should not be prescribed in sleep apnoea; and ideally should be avoided in respiratory distress. The GP said that he would not have given it in an asthmatic unless she had it before (of which there was no record) and that he was unaware of the diagnosis of sleep apnoea (of which diagnosis there was also no medical record).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the general practitioner and medical director have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 4th July. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Person: [redacted] (partner). I have also sent it to the expert witness, [redacted] who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** 9th May 2014 **[SIGNED BY CORONER]**